ROBERT F. HERBOLD, JR., D.P.M., P.A.

Medical and Surgical Treatment
of the Foot & Ankle

ACCREDITED PODIATRY

_____ _____ _____
Patient (Last Name) (First Name) Date of Birth

I wish to be contacted in the following manner (please check all that apply)

_____Home phone_____

_____Work phone_____

_____Cell phone _____

May we leave appointment, billing, or medical information
on your answering machine/voicemail? Yes ____No ____

I give my permission to share appointment, billing, or medical information with the following persons named below

_____

_____

This authorization for release of information covers the period of healthcare from all past, present and future periods _____

Signature of patient or guardian (if minor) _____

4717 SWIFT ROAD • SARASOTA, FL 34231 • (941) 929-1234 • FAX (941) 929-3668

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New Patient Information

Name_____ Date of Birth_____

Address_____

City State Zip

Home Phone_____ Cell Phone_____

Email Address_____

Social Security Number _____

Employer_____ Employer Phone_____

Primary Insurance Company_____

Secondary Insurance Company_____

Is this a work-related Injury? Yes No

Marital Status: Married Single Divorced Widowed

Spouse's Name_____ Social Security Number_____

How were you referred to this office?_____

PLEASE GIVE OUR RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVERS LICENCE TO COPY. OUR OFFICE WILL FILE BOTH PRIMARY AND SECONDARY INSURANCE INFORMATION FOR YOU. OUR OFFICE DOES PARTICIPATE WITH MEDICARE AND MANY MANAGED CARE PLACES. DEDUCTIVLE, COPAYS, CO-INSURANCE, NON-COVERED SERVICES AND SUPPLIES ARE THE PATIENTS RESPONSIBILITY.

Patient or Guardian Signature_____ Date_____

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Age_____Height_____Weight _____Shoe Size_____

Primary Care Physician_____

Medical History (Please circle all that apply):

Diabetes Mellitus	Heart Disease	High Blood Pressure
Mitral Valve Prolapse	Liver Disease	Hepatitis Type _____
Thyroid Condition	Fibromyalgia	Psoriasis
Acid Reflux/GI Ulcers	Diverticulitis	Cancer Type _____
Peripheral Neuropathy	Asthma	Rheumatoid Arthritis
Blood Clot	Kidney Disease	Leg Cramps
Gout	Stroke	Alzheimer Disease
Epilepsy	Emphysema	Scleroderma
Vascular Disease	Other: _____	

Surgical History (Please circle all that apply):

Appendectomy	Angioplasty	Arterial By-Pass
C-section	Cataracts	Carotid Artery Surgery
Gall Bladder	Open Heart	Hysterectomy
Tonsillectomy	Splenectomy	Mastectomy
Back Surgery	Vein Surgery	Pacemaker
Hernia Repair	Fracture Repair	Nephrectomy

Other: _____

Hip Replacement R L Knee Replacement R L

Foot and Ankle (Please circle all that apply):

Bunion	Hammertoes	Neuroma
Bunionette	Joint Implant	Nail
Cyst/Mast	Fracture	Fusion
Arthroscopy	Tendon Repair	

Medications_____

_____

_____

Drug Allergies_____

Tobacco use:_____Year began:_____Year quit:_____

Alcohol use: None Rarely Socially Regularly

Family History (Please circle):

	Diabetes	Heart Disease	Cancer	Hypertension	Arthritis
Mother	Yes	Yes	Yes	Yes	Yes
Father	Yes	Yes	Yes	Yes	Yes
Sibling	Yes	Yes	Yes	Yes	Yes